Lowcountry Psychiatric Associates

25 Clark Summit Dr F201
Bluffton SC 29910
Office 843-757-4737 Fax 843-757-4585

Authorization to Release Medical Information

Patient Name _____

DOB:_____Phone #:_____

Authorization I authorize the following provider(s):
□**Joseph Walters** □**Richard Ford** □**Leah Carter** □**Vicki Bonnell** □**Allison Kenney**
to request and/or release the disclosure of the protected health information to/from the following individuals/organizations:

1.) Name of Relative/Practice/Provider:_____

Address: _____**City**_____**State**_____**Zip**_____

Phone #:_____**Fax #:**_____

2.) Name of Relative/Practice/Provider:_____

Address: _____**City**_____**State**_____**Zip**_____

Phone #:_____**Fax #:**_____

Effective Period This authorization for release of information covers the period of healthcare **from this date forward** unless I revoke the authorization in writing.

_____ All Medical Records
_____ Lab Reports
_____ History & Physical
_____Consultation Reports
_____ Office Notes
_____ Radiology Reports
_____ Operative Reports
_____ Other: _____

Please forward copies to:

Lowcountry Psychiatric Associates or Fax: 843-757-4585
25 Clark Summit Dr Ste F201
Bluffton SC 29910

I understand that my records are protected by the Federal Confidentiality Regulations as well as the provisions of HIPPA and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient/Guardian Signature _____**DATE**_____